

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1804 CERTIFICATE OF DEATH

Reg. Dist. No. 1796

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>	
c. LENGTH OF STAY IN b. <b>5 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pocomoke</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>		d. STREET ADDRESS <b>500 Fifth Avenue</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Adkins</b> Last <b>Adkins</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1866 91</b>
9. AGE (In years last birthday) <b>91</b> yrs.		10. IF UNDER 1 YEAR: Months <b>9</b> Days <b>9</b> Hours <b>58</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Pocomoke, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levin Adkins</b>		14. MOTHER'S MAIDEN NAME <b>Hannah</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>unknown</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Address</b>			

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> DUE TO <b>002x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Far advanced bilateral pulmonary tuberculosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
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21. I certify that I attended the deceased from **Feb. 5, 1958**, to **Feb. 9, 1958**, that I last saw the deceased alive on **Feb. 9, 1958**, and that death occurred at **8:15 A.M.** from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **Henryton, Maryland** DATE SIGNED **2-9-58**

ACTUAL SIGNATURE <b>Edgars M. Maculans</b> M.D.	PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans, Supt. Henryton State Hospital, Henryton, Md.</b>
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/15/58</b>
22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Church</b>	22d. LOCATION (City, town, or county) (State) <b>Pocomoke, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Edgars M. Maculans</b> ADDRESS <b>new church, 201</b>	24a. REC'D BY REGISTRAR <b>FEB 13 1958</b> DATE
24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. 2

FEB 12 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1805 CERTIFICATE OF DEATH

Reg. Dist. No. 1797

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR MD</u>	
c. LENGTH OF STAY IN 1b <u>1 YEAR</u>		d. STREET ADDRESS <u>MARSTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>MARSTON</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LULA STRINE BABBINGTON</u>		4. DATE OF DEATH Month Day Year <u>FEB 1 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/16/1890</u>
9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WORK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BY DAY</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES STRINE</u>		14. MOTHER'S MAIDEN NAME <u>MARY WARNER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-36-753</u>	
17. INFORMANT <u>JOHN STRINE</u>		Address <u>NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular accident</u> <u>443x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-vascular disease</u> DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>4/2/56</u> , 19____, to <u>2/1/58</u> , 19____, that I last saw the deceased alive on <u>1/30/58</u> , 19____, and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>M.E. Robertson</u>		ADDRESS (Street, city or town, state) <u>New Windsor, Md</u>	
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>		DATE SIGNED <u>2/1/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>PIPE CREEK</u>	22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>DDHARTZLER &amp; SONS</u>		ADDRESS <u>NEW WINDSOR MD</u>	
24a. REC'D BY REGISTRAR <u>Feb 4 58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Smith</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Page No. 12

RECEIVED  
FEB 4 1968  
BUREAU V. S.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1806 CERTIFICATE OF DEATH

Reg. Dist. No. 1798

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Charles Fletcher BAILE</u>				4. DATE OF DEATH Month <u>Feb</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 19 1873</u>	9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miller</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Mill</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Uran Baile</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Pennington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>220-01-4091</u>		17. INFORMANT Address <u>Arthur R. Hering - Sykesville, md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, arteriosclerotic heart disease,</u> <u>430.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>myocardial infarction, edema, arteriosclerosis</u> DUE TO (c) <u>generalized</u> INTERVAL BETWEEN ONSET AND DEATH <u>1954 to Feb 1958</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Feb</u> , 1954, to <u>17 Feb</u> , 1958, that I last saw the deceased alive on <u>17 Feb</u> , 1958, and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Alexandria, Md</u>		DATE SIGNED <u>17 Feb 58</u>	
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				<u>SYKESVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		22d. LOCATION (City, town, or county) (State) <u>Edenburg, Carroll, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Sykesville, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1897 CERTIFICATE OF DEATH

Reg. Dist. No.

01799

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>TAYLORSVILLE</u>				d. STREET ADDRESS <u>TAYLORSVILLE</u>			
3. NAME OF DECEASED (Type or print) First <u>PIUS</u> Middle <u>BAKER</u> Last <u>BAKER</u>				4. DATE OF DEATH Month <u>FEB</u> Day <u>13</u> Year <u>1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APRIL 22 - 1889</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER RET.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>TENANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>DALLAS BAKER</u>			
14. MOTHER'S MAIDEN NAME <u>MARGARET WEAVER</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WORLD WART</u>			
16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>DELLA S BAKER NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardia</u> DUE TO (c) <u>Renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>5-6 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>OCT 31</u> , 19 <u>56</u> , to <u>FEB 13</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>FEB 12</u> , 19 <u>58</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>W. Glenn Speicher Westminster MD</u> DATE SIGNED <u>2/14/58</u> ACTUAL SIGNATURE <u>W. Glenn Speicher</u> PHYSICIAN'S NAME (Type) <u>W. GLENN SPEICHER</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/16/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u>		22d. LOCATION (City, town, or county) (State) <u>MT AIRY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DD HARTZLER &amp; SONS NEW WINDSOR</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

BUREAU V. E.

FEB 24 1958

RECEIVED

## 1898 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eldersburg</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Life</u>				d. STREET ADDRESS <u>Chubbville P.O.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Thomas Barnett</u>				4. DATE OF DEATH <u>Feb 18 1958</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 11, 1858</u>	
9. AGE (In years last birthday) <u>99</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Independent</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Agriculture</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel Barnett</u>				14. MOTHER'S MAIDEN NAME <u>Lee</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unk</u>		17. INFORMANT <u>Mrs D.C. Lyons - Chubbville, md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest, arteriosclerotic</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>heart disease, cardiac failure, benign</u> DUE TO (c) <u>prostatic hypertrophy, uremia.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Dec 57 to Feb 58</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Dec 18 1957</u> , to <u>Feb 18 1958</u> , that I last saw the deceased alive on <u>18 Feb 1958</u> , and that death occurred at <u>12:45 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city or town, state) <u>Apexville, md</u>			
DATE SIGNED <u>18 Feb 58</u>							
PHYSICIAN'S NAME (Type) <u>HOWARD E. HALL</u>				SYKESVILLE, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>2-20-58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Freedom</u>		22d. LOCATION (City, town, or county) (State) <u>Eldersburg Carroll md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur H. Haight</u> ADDRESS <u>Chubbville, md</u>				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE				FEB 24 58		<u>W. B. Search</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G226 3-3-58 et

1899

## CERTIFICATE OF DEATH

Reg. Dist. No. 01801

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u> c. LENGTH OF STAY IN 1b <u>9 mo. 21 days.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>4271 Dorby Manor Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Florence</u> Middle <u>Isabel</u> Last <u>Bender</u> <b>4. DATE OF DEATH</b> Month <u>Feb.</u> Day <u>22</u> Year <u>1958</u>				<b>5. SEX</b> <u>F</u> <b>6. COLOR OR RACE</b> <u>W</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>3-24-84</u> <b>9. AGE</b> (In years last birthday) <u>73 1/2</u> yrs <b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u> <b>IF UNDER 24 HRS</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Dependent</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Ohio</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>August Messa</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Margaret</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> <u>Howard Bender</u> Address <u>4271 Dorby Manor Drive.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>C.B.S. associated with senile brain disease</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.B.S. associated with senile brain disease</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)			
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>19</u> Hour <u>  </u> o. m. <u>  </u> p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>4-13</u> , 19 <u>57</u> , to <u>2-22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>58</u> , and that death occurred at <u>12:25</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>							
<b>ACTUAL SIGNATURE</b> <u>Edmund Lusthaus</u> M.D.				<b>PHYSICIAN'S NAME</b> (Type) <u>Edmund Lusthaus M.D.</u> <u>Sykesville, Maryland</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>		<b>22b. DATE THEREOF</b> <u>2-25-58</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>SACRED HEART CEM.</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>7401 GERMAN HILL RD, MD.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Charles L. Zulew</u> ADDRESS <u>9015 CONKLING ST. BALTIMORE 24, MD</u>				<b>24a. REC'D BY REGISTRAR</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>  </u>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1958

8

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100

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## 1810 CERTIFICATE OF DEATH

01802

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutions: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegheny</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>				c. LENGTH OF STAY IN TB <u>7 years 7 months</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>142 Frederick Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>Wheatley</u> Last <u>Berkshire</u>				4. DATE OF DEATH Month <u>II</u> Day <u>2</u> Year <u>1958</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 28, 1869</u>	9. AGE (In years lost birthday) <u>88</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>		11. BIRTHPLACE (State or foreign country) <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>unk.</u>	
13. FATHER'S NAME <u>William Wheatley</u>				14. MOTHER'S MAIDEN NAME <u>Mary Wright</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Springfield Hospital records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>							
420.0 DUE TO							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) <u>Arteriosclerotic heart disease</u> years							
DUE TO							
(c) <u>Generalized arteriosclerosis</u> years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic brain syndrome associated with circulatory disturbance with cerebral arteriosclerosis with psychotic reaction</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>441X</u>							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <u>Springfield</u>				20g. (County) <u>Allegheny</u>		20h. (State) <u>Penn.</u>	
21. I certify that I attended the deceased from <u>July 1, 1950</u> to <u>FEB 2, 1958</u> that I last saw the deceased alive on <u>FEB 2, 1958</u> , and that death occurred at <u>1:10 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED <u>Feb 2, 1958</u>							
ACTUAL SIGNATURE <u>Gertrud Sonnenfeldt</u> M.D. <u>Springfield State Hospital</u>							
PHYSICIAN'S NAME (Type) <u>Gertrud Sonnenfeldt, M.D.</u> <u>Sykesville, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb 5, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rosehill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ruth Silcox</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Alf. Leach</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 1958

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1811

CERTIFICATE OF DEATH

Reg. Dist. No. 01843

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>				c. LENGTH OF STAY IN 1b <u>YEARS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BROADWAY</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LIELA ADELLA BOHN</u>				4. DATE OF DEATH Month Day Year <u>FEB 8 1958</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/29/1878</u>	
9. AGE (In years last birthday) yrs <u>79</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>SAMUEL CROUSE</u>				14. MOTHER'S MAIDEN NAME <u>MARTHA SHRINER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT Address <u>MRS FRANCES BLACK UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>592x</u> DUE TO <u>Artemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Nephritis</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>1-4-</u> , 19 <u>58</u> , to <u>2-8-</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-8-</u> , 19 <u>58</u> , and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>J. H. Legg</u> M.D.				ADDRESS (Street, city or town, state) <u>Union Bridge MD</u> DATE SIGNED <u>2-8-58</u>			
PHYSICIAN'S NAME (Type) <u>T. H. LEGG M.D.</u>				<u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MT. UNION CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Hutzler Union Bridge MD</u>				24a. REC'D BY REGISTRAR <u>DATE FEB 13 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Hutzler</u>	

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DOMINION V. S.

1908

MADE IN U.S.A.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1812 CERTIFICATE OF DEATH

Reg. Dist. No. 1804

1. PLACE OF DEATH o. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL NEW WINDSOR</u>	
c. LENGTH OF STAY IN 1b <u>YEARS</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>C</u> Middle <u>SCOTT</u> Last <u>BOLLINGER</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>1</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV 1 1878</u>
9. AGE (In years last birthday) <u>79</u> yrs		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB BOLLINGER</u>		14. MOTHER'S MAIDEN NAME <u>MARY HANN</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO <u>213-32-6679</u>	
17. INFORMANT <u>MRS HARRY HUGHES</u>		Address <u>RURAL NEW WINDSOR MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-Vascular Disease</u> <u>4-2-51</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <u>  </u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/1/56</u> , 19 <u>  </u> , to <u>2/1/58</u> , 19 <u>  </u> , that I last saw the deceased alive on <u>11/31/58</u> , 19 <u>  </u> , and that death occurred at <u>  </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>2/1/58</u>			
ACTUAL SIGNATURE <u>W. E. Robertson</u> M.D. <u>New Windsor, Md</u>		DATE SIGNED <u>2/1/58</u>	
PHYSICIAN'S NAME (Type) <u>M E ROBERTSON</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/4/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>REFORMED</u>	22d. LOCATION (City, town, or county) (State) <u>TANEY TOWN MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Hartzler</u>		ADDRESS <u>NEW WINDSOR MD</u>	
24a. REC'D BY REGISTRAR <u>  </u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	
DATE <u>FEB 4 '58</u>			

TO HOSPITAL OR FUNERAL HOME: The low requires that the death certificate be executed within 24 hours of death. Pages 4 and 5 may be retained by the hospital or funeral home. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

NOV 10 1900

RECEIVED

1813

## CERTIFICATE OF DEATH

01895

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1249 Washington Blvd.</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Earl</b> Last <b>BRADLEY</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 26, 1901</b>
9. AGE (In years last birthday) <b>56 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sheetmetal Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Bradley</b>		14. MOTHER'S MAIDEN NAME <b>Lena Schmitt</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-03-9708</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage due to hypertension</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>C.B.S. of unknown or uncertain cause, with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 day plus</b> <b>years</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 12, 1957</b> , to <b>February 15, 1958</b> , that I last saw the deceased alive on <b>Feb. 14, 1958</b> , and that death occurred at <b>4:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>2/15/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/18/1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Cathedral</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Flynn &amp; Fleming</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 20 1958</b>	
ADDRESS <b>1422 Light St.</b>		24b. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. B.

13 1958

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1814 CERTIFICATE OF DEATH

Reg. Dist. No. 01806

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> ✓			
c. LENGTH OF STAY IN IB <b>15yrs. 1mo. 13days</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>959 N. Chester St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Howard</b> Middle <b>B.</b> Last <b>BRIGHT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>2,</b> Year <b>1958</b>			
5 SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 7, 1905</b>	
9. AGE (In years last birthday) <b>52</b> yrs		IF UNDER 1 YEAR Months <b>52</b> Days <b>2</b> Hours <b>19</b> Min. <b>58</b>		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Street cleaner</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>William P. Bright</b>				14. MOTHER'S MAIDEN NAME <b>Sophie Obersider</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>			
17. INFORMANT <b>Springfield Hospital Records</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Psychosis with convulsive disorder, epileptic deterioration.</b> <b>Fracture, left clavicle.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Days</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>							20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Pulled down steps by another patient, striking his right shoulder on landing, causing fractured area which proved to be fracture.</b>
20c. TIME OF INJURY Hour <b>10:25</b> a.m. <b>1/15/</b> 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) <b>Sykesville</b> (County) <b>Carroll</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>February 2, 1958</b> , that I last saw the deceased alive on <b>February 2, 1958</b> , and that death occurred at <b>8:55P. M.</b> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield Hospital</b>				DATE SIGNED <b>2/3/58</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.							
NAME (Type) <b>Agustin del Campo</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-6-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip E. Cuch</b>				ADDRESS <b>2716 E. Monument St. Baltimore</b>		24a. REC'D BY REGISTRAR <b>1006 58</b> 24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. M.

EB 6 1958

RECEIVED

**CERTIFICATE OF DEATH**

Reg. Dist. No. **01807**

**1815**

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>1115 Virginia Ave.</b>			
3. NAME OF DECEASED (Type or print) <b>Robert Edward Lee BRINHAM</b>				4. DATE OF DEATH Month <b>February</b> Day <b>4</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>1869</b>	
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Benjamin F. Brinham</b>				14. MOTHER'S MAIDEN NAME <b>Mary Eliza Martin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b>							INTERVAL BETWEEN ONSET AND DEATH Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circ. dist. with cerebral arteriosclerosis with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>February 4, 1958</b> , that I last saw the deceased alive on <b>Feb. 3, 1958</b> , and that death occurred at <b>1:15 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>2/4/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 6 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Lutheran Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brown Creek Church Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>East Funeral Home</b>				ADDRESS <b>Brownsville Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 17 1939

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1816

## CERTIFICATE OF DEATH

Reg. Dist. No. 01898

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admision) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>19 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lucy</b> Middle <b>Murray</b> Last <b>BURDETTE</b>				4. DATE OF DEATH Month <b>February</b> Day <b>3</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 15, 1888</b>	
9. AGE (In years last birthday) yrs. <b>69</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Murray</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Owings</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Impression: C.B.S. associated with arteriosclerosis.</b>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from <b>January 14, 19 58</b> , to <b>February 3, 19 58</b> , that I last saw the deceased alive on <b>February 2, 19 58</b> , and that death occurred at <b>7:00A M.</b> from the causes and on the date stated above.			
21. I certify that I attended the deceased from <b>January 14, 19 58</b> , to <b>February 3, 19 58</b> , that I last saw the deceased alive on <b>February 2, 19 58</b> , and that death occurred at <b>7:00A M.</b> from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/3/58</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 5, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Howard Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Long Corner, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Oliver L. McCarroll</b>				24a. REC'D BY REGISTRAR <b>6 FEB 6 1958</b>		24b. REGISTRAR'S SIGNATURE <b>Charles</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. AIR FORCE

1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1817

## CERTIFICATE OF DEATH

Reg. Dist. No.

01899

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville Md</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
c. LENGTH OF STAY IN 1b <u>49 days</u>				d. STREET ADDRESS <u>1121 Wood Heights Ave.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Nicholas</u> Middle <u>Bychich</u> Last <u>Bychich</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>7</u> Year <u>1958</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-25-81</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Coast Guard</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized.</u>	
13. FATHER'S NAME <u>Nicholas Bychich</u>				14. MOTHER'S MAIDEN NAME <u>Margaret</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Ella Bychich</u>				Address <u>1121 Wood Heights Ave. Baltimore 11, Md.</u>			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).}							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>355x</u> DUE TO <u>Cardiac Arrest</u>							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Huntington's chorea</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>12-20</u> , 19 <u>57</u> , to <u>2-7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2-7</u> , 19 <u>58</u> , and that death occurred at <u>4:55 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Yasuo Takahashi</u> M.D.				ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u>			
PHYSICIAN'S NAME (Type) <u>YASUO TAKAHASHI</u>				DATE SIGNED <u>2-7-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				22b. DATE THEREOF <u>2/11/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>	
22d. LOCATION (City, town, or county) (State) <u>WINDSOR MILL RD, MD</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Eustice E. Donovan</u>				ADDRESS <u>3818 Blundell Ave</u>		24a. REC'D BY REGISTRAR <u>FEB 13 '58</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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RECEIVED  
JAN 10 1958

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1819

## CERTIFICATE OF DEATH

Reg. Dist. No. 01811

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville, Maryland</b> c. LENGTH OF STAY IN HOSPITAL OR INSTITUTION <b>4 yrs. 1 mo. 12 das.</b> d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore 24</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 24</b> d. STREET ADDRESS <b>324 South High</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosina (Rose) Ciancuilli Copaldo</b>				4. DATE OF DEATH Month Day Year <b>February 18 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept., 1866</b>	
9. AGE (In years last birthday) <b>91 yrs</b>		IF UNDER 1 YEAR Months Days Hours Min		IF UNDER 24 HRS Months Days Hours Min			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Italy</b>		11. BIRTHPLACE (State or foreign country) <b>Italy</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>							
13. FATHER'S NAME <b>Felix Ciancuilli</b>				14. MOTHER'S MAIDEN NAME <b>Marie Cancellale</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Springfield State Hospital Records.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO <b>Chronic Myocarditis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized Arteriosclerosis</b> (c) <b>Generalized Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b> <b>10 yrs.</b> <b>15 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <b>Chronic Brain Syndrome associated with senile brain disease with psychotic reaction</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1-7</b> , 19 <b>54</b> , to <b>2-18</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-18</b> , 19 <b>58</b> , and that death occurred at <b>6:45 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-19-58</b>							
ACTUAL SIGNATURE <b>Morrell N. Mastin</b> M.D.				PHYSICIAN'S NAME (Type) <b>Morrell N. Mastin, M. D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran -3000 E. Baltimore Street</b>				24a. REC'D BY REGISTRAR <b>FEB 25 1958</b>		24b. REGISTRAR'S SIGNATURE <b>C. J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7, File 226 2-2-58 et

1818

## CERTIFICATE OF DEATH

Reg. Dist. No. 01810

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1mo. 14 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>322 Park Ave.</b>			
3. NAME OF DECEASED (Type or print) First <b>Fook</b> Middle <b>CHIN</b> Last <b>CHIN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Chinese</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> ? DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 3, 1864</b>	
9. AGE (In years last birthday) <b>93 yrs.</b>		IF UNDER 1 YEAR Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min. <b>93</b>		IF UNDER 24 HRS Months <b>93</b> Days <b>93</b> Hours <b>93</b> Min. <b>93</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>China</b>	
12. CITIZEN OF WHAT COUNTRY? <b>China</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) <b>C.B.S. associated with senile brain disease with psychotic reaction.</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <b>January 10, 19 58</b> to <b>February 24, 19 58</b> , that I last saw the deceased alive on <b>February 23, 19 58</b> , and that death occurred at <b>5:46 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/24/58</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Springfield State Hospital</b>							
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, or REMOVAL (Specify)				22b. DATE OF REMOVAL (Specify)		22c. NAME OF CEMETERY OR CREMATORY	
<b>Burial Feb 26/58</b>				<b>2/26/58</b>		<b>St. Lawrence</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stewart H. Brown</b>				ADDRESS <b>Balto - Md</b>		24a. REC'D BY REGISTRAR <b>DATE 2-24-58</b>	
24b. REGISTRAR'S SIGNATURE <b>Stewart H. Brown</b>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 20 1968

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1820

## CERTIFICATE OF DEATH

01812

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b> <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>lyr. lmo. 29 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>207 E. Washington St.</b> <b>1200 Nalley St., Balto. 2.</b>	
3. NAME OF DECEASED (Type or print) First <b>Oscar</b> Middle <b>McClelland</b> Last <b>CUMMINGS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 26, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>10</b> Hours <b>10</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Contractor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Business</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>David Cummings</b>		14. MOTHER'S MAIDEN NAME <b>Susan Hawbaker</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>430.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circulatory disturbance, with cerebral arterio-sclerosis, with psychotic reaction.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Dec. 11, 1956</b> , to <b>February 10, 1958</b> , that I last saw the deceased alive on <b>February 10, 1958</b> , and that death occurred at <b>3:55 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/10/58</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/13/1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Hagerstown, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. Franklin Perry</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 13 58</b>	24b. REGISTRAR'S SIGNATURE <b>W. H. Houch</b>

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MAU V. S.

1938

RECEIVED

## 1821 CERTIFICATE OF DEATH

01813

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>12 y 9 m 8 d</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore, Md.</b>			
				d. STREET ADDRESS <b>1711 Bethel Street</b>			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>L</b> Last <b>Dean</b>				4. DATE OF DEATH Month <b>2</b> Day <b>23</b> Year <b>19 58</b>			
5. SEX <b>Fem</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-5-72</b>	
				9. AGE (In years last birthday) yrs. <b>85</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
				11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <b>Charles N. Mayers</b>				14. MOTHER'S MAIDEN NAME <b>Louise Yoh</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>no</b>				16. SOCIAL SECURITY NO <b>unkn</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Bilateral pulmonary Tuberculosis, far advanced, active</b> years <b>002X</b>							
DUE TO (b) _____							
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C, D, S assoc. with senile brain disease with psych. reaction</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <b>10-20-1954</b> , to <b>2-23-1958</b> , that I last saw the deceased alive on <b>2-23-1958</b> , and that death occurred at <b>2:00 PM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) _____ DATE SIGNED _____							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				M.D. <b>Springfield State Hospital</b> <b>2-23-58</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>2-25-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>OBITUARY</b>		22d. LOCATION (City, town, or county) (State) <b>BALTO.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>McClary Thomas Howell</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 26 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Over...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death; Page 4 may be retained in the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

RECEIVED

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01814

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
BIM 2/57

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural -- Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>25 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <b>Buffalo Road</b>	
3. NAME OF DECEASED (Type or print) <b>CASPER W. DILLER</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>16,</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-28-1881</b>
9. AGE (In years) <b>76</b> yrs		10. IF UNDER 1 YEAR Months Days Hours M'n	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John H. Diller</b>		14. MOTHER'S MAIDEN NAME <b>Ida M. Kreglo</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Mrs. Ella M. Diller,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerosis</b> <b>4/20/1</b> DUE TO (b) <b>Coronary Insufficiency</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Minute</b> <b>Several years</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James J. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>JAMES T. MARSH</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-22-1958</b>	
22c. NAME OF CEMETERY <b>Prospect</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz, Winfield, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Q. W. L. S. 1</b>	

DATE SIGNED

**2-20-58**

BUREAU V. B.

FEB 01 1958

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1823 CERTIFICATE OF DEATH

Reg. Dist. No. 11815

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>		c. LENGTH OF STAY IN 1b <u>YEARS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>UNION BRIDGE</u>	
f. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDNA FLORENCE DOWERY</u>		4. DATE OF DEATH Month Day Year <u>FEB 21 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>COL</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAR 30 - 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>ANDREW HILL</u>		14. MOTHER'S MAIDEN NAME <u>REBECCA WILLIAMS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-1216-208</u>	
17. INFORMANT Address <u>MRS JUNE GREEN UNION BRIDGE MD</u>			
18. CAUSE OF DEATH [Enter only one cause per item for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-21-1958</u> to <u>2-21-1958</u> , that I last saw the deceased alive on <u>2-21-1958</u> , and that death occurred at <u>9:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Union Bridge Md</u> DATE SIGNED <u>2-22-58</u> ACTUAL SIGNATURE <u>J. H. Legg</u> M.D. PHYSICIAN'S NAME (Type) <u>T. H. LEGG MD</u> <u>UNION BRIDGE MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/24/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>MT OLIVE</u>		22d. LOCATION (City, town, or county) (State) <u>FREDERICK CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>D. H. Harkley</u> ADDRESS <u>Union Bridge, Md.</u>		24a. RECEIVED BY REGISTRAR DATE <u>2-22-58</u>	
24b. REGISTRAR'S SIGNATURE <u>W. H. Harkley</u>			

WILLIAM V. B.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1824

CERTIFICATE OF DEATH

Reg. Dist. No. 01816

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>12 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Ruth Marie Edwards DURST</b>				4. DATE OF DEATH Month Day Year <b>February 20, 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 27, 1899</b>	
9. AGE (in years last birthday) <b>58</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Theodore Edwards</b>			
14. MOTHER'S MAIDEN NAME <b>Addie Brown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>-</b>				17. INFORMANT <b>Springfield State Hospital</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>471x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with intracranial infection (encephalitis) with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH Days  Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 8, 19 58</b> , to <b>February 20, 19 58</b> , that I last saw the deceased alive on <b>February 20, 19 58</b> , and that death occurred at <b>10:20A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/20/58</b> ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D. PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>CREMATION</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>FT. LINCOLN CREMATORY</b>		22d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 25 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Humphrey</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1945

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 9-11-225 3-5-54 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

01817

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Taneytown</b>		c. LENGTH OF STAY IN 1b <b>42 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>11 Fairview Avenue</b>		d. STREET ADDRESS <b>11 Fairview Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>Elizabeth</b> Last <b>Essig</b>		4. DATE OF DEATH Month <b>February</b> Day <b>23</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 17, 1888 1886 69 71</b> yrs
9. AGE (In years last birthday) <b>69 71</b> yrs		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife, Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Butler Co., Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Stratton</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Maitland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No.</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mary Lou Essig</b> Address <b>Mary Lou Essig, 11 Fairview Ave., Taneytown, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes Mellitus</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>8 years</b>
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 24, 1954</b> , to <b>Feb 23, 1958</b> , that I last saw the deceased alive on <b>Feb 13, 1958</b> , and that death occurred at <b>2:45 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Emm. &amp; S. Burg, Md</b> DATE SIGNED <b>Feb 24, 1958</b>			
ACTUAL SIGNATURE <b>Charles R Williams</b> M.D.		PHYSICIAN'S NAME (Type) <b>Charles R Williams</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Reformed Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Taneytown, Carroll Co., Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A Little</b>		ADDRESS <b>Littlestown, Pa.</b>	24a. REC'D BY REGISTRAR DATE <b>FEB 25 58</b>
		24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD V. S.

1870

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1826

## CERTIFICATE OF DEATH

01818

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL WESTMINSTER</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL x WESTMINSTER</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First Middle Last <b>WILLIAM L FARVER</b>				4. DATE OF DEATH Month Day Year <b>FEB 1 1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT 17 - 1875</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT L FARVER</b>				14. MOTHER'S MAIDEN NAME <b>REBECCA SHIPLEY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT Address <b>MRS WILBUR NAILL WESTMINSTER MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>LOBAR PNEUMONIA</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>3 days -</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arterio-Sclerotic Cardiovascular Disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from <b>Dec - 1955</b> to <b>Feb 1 1958</b> , that I last saw the deceased alive on <b>Jan 31 1958</b> , and that death occurred at <b>10:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>James T. Marsh</b> M.D.				ADDRESS (Street, city or town, state) <b>105 E. Main St - Westminster Md</b>		DATE SIGNED <b>2-1-58</b>	
PHYSICIAN'S NAME (Type) <b>JAMES T. MARSH</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2/4/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>EBENEZER</b>		22d. LOCATION (City, town, or county) <b>WINFIELD</b>		(State) <b>MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. Hartzler &amp; Sons New Windsor Md</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Carl Smith</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 7 1912

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1827 CERTIFICATE OF DEATH

01819

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pr. George's Co.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN IS <b>since 3/27/13</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>16</b>			
3 NAME OF DECEASED (Type or print) First <b>Paul</b> Middle <b>---</b> Last <b>FIEDOR</b>				4. DATE OF DEATH Month <b>February</b> Day <b>6</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1871</b>	
9. AGE (In years last birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min <b>---</b>		IF UNDER 24 HRS. Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min <b>---</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>---</b>			
17. INFORMANT <b>Records of Springfield State Hospital</b>				Address <b>Sykesville, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> less than 6 hours							
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Arteriosclerotic cardiovascular disease</b> 2 weeks							
DUE TO (c) <b>Generalized arteriosclerosis</b> more than 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, hebephrenic type</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>---</b> p. m. <b>---</b> 19 <b>---</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>April</b> , 19 <b>56</b> to <b>Febr. 6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Febr. 4</b> , 19 <b>58</b> , and that death occurred at <b>5 A.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Walter Knopp</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>			
DATE SIGNED <b>2/6/58</b>							
PHYSICIAN'S NAME (Type) <b>Walter Knopp, M.D.</b>				Sykesville, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>---</b>		22b. DATE THEREOF <b>2.6.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore - Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank H. Newell</b>				ADDRESS <b>Pittsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 58</b>	
				24b. REGISTRAR'S SIGNATURE <b>---</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 11

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1828

Item 9 Film 226 2-28-58 et

## CERTIFICATE OF DEATH

01820

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>3 yrs. 15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hancock</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Rt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Abraham FINK</b>				4. DATE OF DEATH Month Day Year <b>February 19 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-3-1882</b>	
9. AGE (In years last birthday) <b>75 76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>unknown</b>				14. MOTHER'S MAIDEN NAME <b>unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>no</b> (If yes, give war or dates of service) <b>-</b>				16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield State Hospital Records</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>Not due to</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic brain syndrome associated with arteriosclerosis</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 4, 1955</b> , to <b>February 19 1958</b> , that I last saw the deceased alive on <b>February 19, 1958</b> , and that death occurred at <b>2:00 AM</b> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>				DATE SIGNED <b>2/19/58</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2.24.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peters Catholic</b>		22d. LOCATION (City, town, or county) (State) <b>Hancock Washington Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard F. Stone</b> ADDRESS <b>Hancock Md.</b>				24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

V. S.

1875

THE AMERICAN  
LIBRARY

1829

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN lb <b>1 yr.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Charles Calvin FITZ</b>		4. DATE OF DEATH Month Day Year <b>February 5, 1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 26, 1868</b>
9. AGE (In years last birthday) yrs. <b>89</b>		10. IF UNDER 1 YEAR: Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Levi Fitz</b>		14. MOTHER'S MAIDEN NAME <b>Ellen Willhide</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None -</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b>			
Canditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Arteriosclerotic heart disease</b>			
(c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circ. dist. with cerebral arteriosclerosis, with psychotic reaction.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 5, 1957</b> , to <b>February 5, 1958</b> , that I last saw the deceased alive on <b>Feb. 5, 1958</b> , and that death occurred at <b>1:25 P M</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.		DATE SIGNED <b>2/5/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/8/1958</b>	
22c. NAME OF CEMETERY OR CATHARTORY <b>United Brethren</b>		22d. LOCATION (City, town, or county) (State) <b>Thurmont, Frederick Co. Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>S. L. Allison</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 10 1958</b>	
ADDRESS <b>Emmitsburg, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur Smith</b>	

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1959

27

1-2-59

1830

## CERTIFICATE OF DEATH

Reg. Dist. No. 1822

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Mt. Airy</b>		c. LENGTH OF STAY IN 1b <b>52 yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>Gillis Road</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>OTHO</b> Middle <b>AUGUSTUS</b> Last <b>FLEMING</b>		4. DATE OF DEATH Month <b>FEB.</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-4-1874 1882</b>
9. AGE (In years last birthday) <b>75 yrs.</b>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>owner</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Otho P. Fleming</b>		14. MOTHER'S MAIDEN NAME <b>Cordelia Mullinix</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>none</b>	
17. INFORMANT <b>Mrs. Elsie G. Fleming,</b>		Address <b>Same</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>11:20 O</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>The next day</b> <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug</b> 19 <b>55</b> , to <b>Feb</b> 19 <b>58</b> , that I last saw the deceased alive on <b>Feb 22</b> 19 <b>58</b> , and that death occurred at <b>7:15 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>2/24/58</b>			
ACTUAL SIGNATURE <b>W.B. Culwell</b> M.D.			
PHYSICIAN'S NAME (Type) <b>W. B. CULWELL</b>		<b>not. Airy, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-26-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Taylorsville</b>	22d. LOCATION (City, town, or county) (State) <b>Carroll Co., Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>		ADDRESS <b>Winfield, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE A. C. C. C.



01823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>20 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> f. STREET ADDRESS <b>2233 N. Calvert St.</b>	
3. NAME OF DECEASED (Type or print) First <b>Mrs Herbert</b> Middle <b>Frizzel</b> Last <b>Frizzel</b>		4. DATE OF DEATH Month <b>February</b> Day <b>9</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 23 1878</b>
9. AGE (In years last birthday) yrs. <b>79</b>		IF UNDER 1 YEAR Months <b>79</b> Days <b>79</b> Hours <b>79</b> Min. <b>79</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>electrician (ret'd)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland (Baltimore)</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Wm Frizzel</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Ann (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown</b>		16. SOCIAL SECURITY NO. <b>Records of Springfield State Hospital</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia Paranoid Type</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>1 year</b> <b>10 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>April 1956</b> , to <b>Febr. 8 1958</b> , that I last saw the deceased alive on <b>Febr. 8 1958</b> , and that death occurred at <b>8:15 A.M.</b> , from the causes and on the date stated above. <b>Walter Knopp</b> M.D. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville, Md.</b> DATE SIGNED <b>February 9, 1958</b>			
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 11 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. H. H.</b>			

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 must be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EB 11 1959

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1832

CERTIFICATE OF DEATH

01824

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>13 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>Baltimore 31, Maryland</b>			
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>COMBERT</b> Last <b>COMBERT</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 1, 1875</b>		9. AGE (In years less birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Frank Gimbert</b>				14. MOTHER'S MAIDEN NAME <b>Regina -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No -</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Generalized arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE, CONDITION GIVEN IN PART I (a) <b>C.B.S. due to cerebral arteriosclerosis.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Years</b> <b>Years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <b>19</b> Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 30, 19 58</b> to <b>February 12, 19 58</b> , that I last saw the deceased alive on <b>February 12, 19 58</b> , and that death occurred at <b>8:50A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>		DATE SIGNED <b>2/12/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>				<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Philip H. Hargrove</b>				ADDRESS <b>2024 Orleans St</b>		24a. REC'D BY REGISTRAR DATE <b>Feb 18 1958</b>	
				24b. REGISTRAR'S SIGNATURE <b>A. J. Smith</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD Y. S.

FEB 18 1903

100-1

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03094

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Washington</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>	
c. LENGTH OF STAY IN 1b <b>13yrs. 4mos. 28days</b>		d. STREET ADDRESS <b>Unknown</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Springfield State Hospital</b>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Mary Virginia GREEN</b>		4. DATE OF DEATH Month Day Year <b>February 25, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1908</b>
9. AGE (In years last birthday) <b>49 yrs</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Luther Green</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Scuffins</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>721</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary embolism</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia</b>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>C.B.S. assoc. with C.N.S. syphilis, meningoencephalitic, with psychotic reaction.</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>Slipped &amp; fell on icy road.</b>	
20c. TIME OF INJURY Month, Day, Year Hour p. m. <b>Feb. 4, 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Sykesville Carroll Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James T. Marsh</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James T. Marsh, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		22b. DATE THEREOF <b>3-6-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Springfield Hospital</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur A. Knight</b>		24a. REGISTERED REGISTRAR <b>W. H. H. 58</b>	
		24b. REGISTRAR'S SIGNATURE <b>W. H. H.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral home. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAR 11 1938

RECEIVED

Item 2 100-226 3-10-58 at

1834

## CERTIFICATE OF DEATH

Reg. Dist. No. 01825

1 PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARMOUTH CITY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SYKESVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
c. LENGTH OF STAY IN 1b <u>11 years 2 mo</u>		d. STREET ADDRESS <u>219 North High Street</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>SPRINGFIELD S. HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DOROTHY ELIZABETH GROSS</u>		4. DATE OF DEATH Month Day Year <u>FEBRUARY 17 1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>DEC-26, 1911</u>
9. AGE (In years last birthday) <u>46</u> yrs		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>JOHN T. PHILLIPS</u>		14. MOTHER'S MAIDEN NAME <u>ANNA C. SLIBOTT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		16. SOCIAL SECURITY NO <u>-</u>	
17. INFORMANT <u>RECORD IN HOSPITAL</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4' DUE TO <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>minutes</u> (c) <u>minutes</u>			INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PSYCHOSIS WITH EPIDEMIC ENCEPHALITIS</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>DEC-13, 1946</u> , to <u>FEB 17, 1958</u> , that I last saw the deceased alive on <u>FEBRUARY 17, 1958</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Rita S. Glahn</u>		DATE SIGNED <u>Springfield State Hosp</u>	
PHYSICIAN'S NAME (Type) <u>RITA S GLAHN</u>		<u>SYKESVILLE, MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>	22b. DATE THEREOF <u>2-18-58</u>	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State) <u>FALL RIVER, MASS.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tracy Funeral Home - Catoeville, Md</u>		24a. REC'D BY REGISTRAR <u>Feb 21 58</u>	
ADDRESS <u>Tracy Funeral Home - Catoeville, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Don</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1835

## CERTIFICATE OF DEATH

Reg. Dist. No. 01826

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural--Woodbine</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Rural--Woodbine</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION			d. STREET ADDRESS <b>Woodbine, Road</b>		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>EDNA</b> Middle <b>M.</b> Last <b>HEWITT</b>			4. DATE OF DEATH Month <b>FEB.</b> Day <b>22,</b> Year <b>1958</b>		
5. SEX <b>female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-18-1886</b>		9. AGE (In years last birthday) <b>71</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Michael Glennan</b>			14. MOTHER'S MAIDEN NAME <b>Mahala Brandenburg</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>----</b>	17. INFORMANT <b>Robert R. Hewitt, Same</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC CARDIO*VASCULAR DISEASE</b> <b>22, 1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>senility</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>20 yrs</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1955</b> , 19____, to <b>2.22.58</b> , 19____, that I last saw the deceased alive on <b>2.22.58</b> , and that death occurred at <b>3:30P</b> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>[Signature]</i>			ADDRESS (Street, city or town, state) <b>Liberty Road at Eldersburg</b> DATE SIGNED <b>2.22.58</b>		
PHYSICIAN'S NAME (Type) <b>Wm. H. Lawson, Jr., M.D.</b>			<b>Sykesville P.O., Maryland</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-25-1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Springfield</b>		22d. LOCATION (City, town, or county) (State) <b>Sykesville, Md.,</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. M. Waltz,</b>			ADDRESS <b>Winfield, Md.</b>		24a. REC'D BY REGISTRAR <b>FL 26 30</b> DATE
			24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

EDWARD A. S.

1151 AVENUE

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1836

Reg. Dist. No. 01827

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR RURAL</b>				c. LENGTH OF STAY IN 1b <b>YEARS</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>NEW WINDSOR RURAL</b>			
				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>EAKL</b> Last <b>HOFF</b>				4. DATE OF DEATH Month <b>FEB</b> Day <b>27</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB 7-1899</b>		9. AGE In years (last birthday) <b>59</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN H HOFF</b>				14. MOTHER'S MAIDEN NAME <b>CATHERINE FROCK</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>220-18-1070</b>		17. INFORMANT <b>LONIE HOFF NEW WINDSOR MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HANGING</b> DUE TO Conditions, if any, which gave rise to immediate (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Strangled by neck</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>2 27 1958</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home from</b>		20f. (City or town) (County) (State) <b>New Windsor Carroll MD</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Notatural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>James T. Marsh</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>JAMES T MARSH</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL-CREATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>3/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>PIPE CREEK</b>		22d. LOCATION (City, town, or county) (State) <b>CARROLL CO MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>DD Hartzler &amp; Sons, New Windsor MD</b>				24a. REC'D BY REGISTRAR DATE <b>MAR 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. A.

1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1837 CERTIFICATE OF DEATH

01825

Reg. Dist. No.

1. PLACE OF DEATH o COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o STATE <b>Maryland</b> b. COUNT <b>Baltimore City 311</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN TB <b>5 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 18</b>	
f. STREET ADDRESS <b>1660 E. Coldspring Lane</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Blanche</b> Middle <b>Emma</b> Last <b>Kelso</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 20, 1886</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR: Months <b>72</b> Days <b>0</b> Hours <b>0</b> Min <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Clayton Dress Shop</b>	
11. BIRTHPLACE (State or foreign country) <b>Acomac Co., Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Benjamin Kelso</b>		14. MOTHER'S MAIDEN NAME <b>Emma (unknown)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>Springfield Hospital records</b>	
17. INFORMANT <b>Springfield Hospital records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>420.0 not DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>491x</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 12, 1958</b> , to <b>February 17, 1958</b> , that I last saw the deceased alive on <b>February 17, 1958</b> , and that death occurred at <b>6:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		DATE SIGNED <b>2-18-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-21-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore County</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>		24a. REC'D BY REGISTRAR <b>FEB 21 '58</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Alberstein</b>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 21 1963

RECEIVED  
FEB 21 1963

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1838

CERTIFICATE OF DEATH

Reg. Dist. No.

01829

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
c. LENGTH OF STAY IN 1b <b>1 mo. 12 days</b>				d. STREET ADDRESS <b>2712 Halcyon Avenue</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Anna Catherine Dehring KEYS</b>				4. DATE OF DEATH Month Day Year <b>February 14, 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>November 8, 1886</b>	
9. AGE (In years last birthday) <b>71</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Herbert-Dehring Herman Dehring</b>				14. MOTHER'S MAIDEN NAME <b>Henrietta -</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-03 - 798</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atrial paroxysmal tachycardia due to unknown cause</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH Hours Years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January 2, 19 58</b> to <b>February 14, 19 58</b> , that I last saw the deceased alive on <b>February 13, 19 58</b> , and that death occurred at <b>5:18 A</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital 2/14/58</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				M.D. <b>Springfield State Hospital</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				<b>Sykesville, Maryland.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Lutheran Cem. Sykesville, Md.</b>		22d. LOCATION (City, town, or county) (State) <b>-md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Luxon Funeral Home 7401 Belair Rd.</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 18 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 18

RECEIVED  
FEB 18 1880

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1839

CERTIFICATE OF DEATH

Reg. Dist. No. 01830

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>521 S. Port Street</b>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>KIELIAN</b> Last <b>KIELIAN</b>				4. DATE OF DEATH Month <b>February</b> Day <b>12,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Unknown</b>	9. AGE (In years last birthday) <b>58 ?</b> yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic myocardial infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) <b>Arteriosclerosis, generalized and severe</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>  <b>Years</b>  <b>Years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. assoc. with circ. dist., with cerebral arteriosclerosis, with psychotic reaction.</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 12, 1956</b> , to <b>February 12, 1958</b> , that I last saw the deceased alive on <b>February 12, 1958</b> , and that death occurred at <b>10:25 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Springfield State Hospital</b> <b>2/13/58</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D.				PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>				22b. DATE THEREOF <b>2-17-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Stanislaus Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>				23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc. 1217 St. Paul Street</b>			
24a. REC'D BY REGISTRAR DATE <b>FEB 18 '58</b>				24b. REGISTRAR'S SIGNATURE <b>Cal. Smith</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. DEPARTMENT OF AGRICULTURE

W. A. R. 1911

1840

## CERTIFICATE OF DEATH

01831

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>8 m 2 d</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 2, Md.</b>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>101 E. Mt. Royal Avenue</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Maude</b> Last <b>Kittlewell</b>		4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Fem</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Kittlewell</b>		14. MOTHER'S MAIDEN NAME <b>Josephine Cole</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>unkn</b>	
17. INFORMANT <b>S.S. Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b>			<b>years</b>
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
(b) <b>Generalized Arteriosclerosis</b>			<b>years</b>
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
<b>Chronic brain syndr. assoc. with cerebral arteriosclerosis</b>			
<b>Possible dementia due to Pellagra</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>6-13-1957</b> to <b>2-15-1958</b> , that I last saw the deceased alive on <b>2-15-1958</b> , and that death occurred at <b>10:45 A</b> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b>	
DATE SIGNED <b>2-15-58</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 18, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>	22d. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc.</b>		ADDRESS <b>1900 Rutaw Place</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Ch. Beach</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1841

## CERTIFICATE OF DEATH

01832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) b. COUNTY <u>Carroll</u> STATE <u>Maryland</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>✓</u>		d. STREET ADDRESS <u>✓</u>	
3. NAME OF DECEASED (Type or print) <u>EDWARD - H - Knebel</u>		4. DATE OF DEATH <u>Feb 10 - 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 30 - 1870</u>
9. AGE (In years last birthday) <u>88</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Stone Mason</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>William Kuelles</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Albaugh</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>166-12-5452</u>	
17. INFORMANT <u>Charles Kuelles - Manchester Md</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Anteroseptal</u> DUE TO (c) <u>5 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1947</u> to <u>Feb 10, 1958</u> that I last saw the deceased alive on <u>Feb 10, 1958</u> and that death occurred at <u>9:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>W. H. Foard</u> M.D.		DATE SIGNED <u>2/11/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. Foard M.D.</u>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Feb 13 - 1958</u>	<u>United Brothers</u>	<u>Manchester Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edna A. Tipton</u> ADDRESS <u>Hamstead Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 13 '58</u>	
		24b. REGISTRAR'S SIGNATURE <u>W. H. Foard</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. V. S.

80-8

DEAD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01833

1842

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b> c. LENGTH OF STAY IN 1b <b>since 2-15-57</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City-</b> d. STREET ADDRESS <b>6003 Kenwood Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Joseph</b> Last <b>KOTRAS</b>		4. DATE OF DEATH Month <b>Feb.</b> Day <b>21,</b> Year <b>1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 23, 1882</b>
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>	IF UNDER 24 HRS. Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter, cabinetmaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--- May Co.</b>	11. BIRTHPLACE (State or foreign country) <b>Czechoslovakia</b>
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Ignatz Kotras</b>	
14. MOTHER'S MAIDEN NAME <b>--- Maximiliana Urban</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>216-10-2065</b>		17. INFORMANT <b>Records of Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO <b>4221</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic Cardiovascular disease</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>more than 3y.</b> <b>more than 10 y.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I <b>Chronic brain syndrome assoc. with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>4/11 X</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <b>---</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>---</b> o. m. <b>---</b> p. m. <b>---</b> 19 <b>---</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> off work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>		20f. (City or town) <b>---</b> (County) <b>---</b> (State) <b>---</b>	
21. I certify that I attended the deceased from <b>Feb. 15</b> , 19 <b>57</b> , to <b>Febr. 21</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Febr. 21</b> , 19 <b>58</b> , and that death occurred at <b>9:55 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>Walter Knopp</b>			
ACTUAL SIGNATURE <b>Walter Knopp</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Walter Knopp</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/25/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cem.</b>	22d. LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b> <b>2601-3-5 E. Madison St.</b>		24a. REC'D BY REGISTRAR <b>---</b> 24b. REGISTRAR'S SIGNATURE <b>---</b> DATE <b>FEB 25 58</b>	

BUREAU V. S.

1918



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1843

CERTIFICATE OF DEATH

01834

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Germantown</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>R.F.D. #1</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Grover Daniel LINTHICUM</b>		4. DATE OF DEATH Month Day Year <b>Feb. 22 1958</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-18-87</b>
9. AGE (In years last birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Germantown, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George F. Linthicum</b>		14. MOTHER'S MAIDEN NAME <b>Irene Tabler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>—</b> (If yes, give war or dates of service) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>records of Springfield State Hospital</b>		Address <b>—</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>334 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral arteriosclerosis with psychotic reaction</b> DUE TO (c) <b>—</b>			INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs</b> <b>about 8 yrs</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan. 19, 1956</b> to <b>Feb. 22 1958</b> , that I last saw the deceased alive on <b>Feb. 22 1958</b> , and that death occurred at <b>9:00 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>—</b>			
ACTUAL SIGNATURE <b>Martin Gross</b> M.D. <b>Springfield State Hospital</b>		PHYSICIAN'S NAME (Type) <b>Martin Gross, M.D.</b> <b>Sykesville, Md</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>2/26/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baptist Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cedar Grove, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ray W. Barber</b> ADDRESS <b>Laytonsville, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 26 '58</b> 24b. REGISTRAR'S SIGNATURE <b>—</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

FEB

DEC

1844

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>206 N. Milton Ave.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>LOCHNER</b> Last		4. DATE OF DEATH Month <b>February</b> Day <b>26</b> , Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 30, 1864</b>
9. AGE (In years last birthday) <b>94</b> yrs.		IF UNDER 1 YEAR: IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Unknown Joseph Steinberger</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown Theresa Reisberger</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> <b>422.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Bronchopneumonia due to aspiration</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. due to arteriosclerosis.</b> <b>441 X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>Days</b>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		20c. TIME OF INJURY Month, Day, Year Hour o. m p. m <b>19</b>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>January 2/13/ 19 58</b> to <b>2/26/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2/26/58</b> , 19 <b>58</b> , and that death occurred at <b>6:10P</b> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield Hospital</b> DATE SIGNED <b>2/27/58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Mar. 3, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John A. Moran - 3000 E. Baltimore Street</b>		24a. REC'D BY REGISTRAR DATE <b>MAR 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Al L. Smith</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5

1845

CERTIFICATE OF DEATH

Reg. Dist. No. 01835

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2yrs. 2mos. 25days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Agnes</b> Last <b>Lookabaugh</b>		4. DATE OF DEATH Month <b>February</b> Day <b>17</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-23-1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		10. IF UNDER 1 YEAR Months <b>87</b>	10. IF UNDER 24 HRS. Days <b>87</b> Hours <b>87</b> Min. <b>87</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Heury Houck</b>		14. MOTHER'S MAIDEN NAME <b>Leah May ?</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>Springfield Hospital Records</b>	
17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X not DUE TO</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with circulatory disturbance, with cerebral arteriosclerosis, with psychotic reaction, with diabetes mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-23</b> , 19 <b>55</b> , to <b>2-17</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-16</b> , 19 <b>58</b> , and that death occurred at <b>9:50 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville,</b> DATE SIGNED <b>2-17-58</b>			
ACTUAL SIGNATURE <b>Agustin del Campo</b> M.D. <b>Agustin del Campo, M.D.</b> <b>Maryland</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b> <b>Maryland</b> <b>2-17-58</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/20/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Burns Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Chapinboro Penna.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W.J. Horneant, Hagerstown, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Agustin del Campo</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

5160-107

BUREAU V. F.

1958

WEL

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Manchester</u>	
c. LENGTH OF STAY IN 1b <u>11 yrs</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHESTER</u> First Middle Last		4. DATE OF DEATH <u>Feb 13</u> Month Day Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3 - 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ephraim Martin</u>		14. MOTHER'S MAIDEN NAME <u>Rachel A Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO <u>720</u>	
17. INFORMANT <u>Ladice M. Martin</u> Address <u>Manchester Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4. DUE TO <u>1 Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 Hypertension</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> <u>8 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Nov 1950</u> , to <u>Jan 13 1958</u> , that I last saw the deceased alive on <u>Jan 12 1958</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above ADDRESS (Street, city or town, state) <u>Manchester, Md</u> DATE SIGNED <u>2/13/58</u>			
ACTUAL SIGNATURE <u>W H Foard</u>		M. D. <u>Manchester, Md</u>	
PHYSICIAN'S NAME (Type) <u>W H Foard MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 16 - 1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grace cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Balto Co Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edie A. Hopton</u> ADDRESS <u>Hampstead Md</u>		24a. REC'D BY REGISTRAR <u>FEB 13 1958</u> 24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death. The law requires that the death certificate be completed within 24 hours after death.

EDWARD V. E.

FEB 18 1913

100

1847

## CERTIFICATE OF DEATH

Reg. Dist. No.

01838

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Minnie</b> Middle <b>May</b> Last <b>McMillan</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-26-1873</b>
9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Zimmerman</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Mahaney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senile psychosis - simple deterioration</b>			INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>October 20 19 54</b> , to <b>February 18, 19 58</b> , that I last saw the deceased alive on <b>February 18, 19 58</b> , and that death occurred at <b>1:00 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.		ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-18-58</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Feb. 22, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Birtaw Place</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Edmund</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1900

RECEIVED

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1848

## CERTIFICATE OF DEATH

Reg. Dist. No.

01839

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>				c. LENGTH OF STAY IN 1b <b>12 Years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R. D. 6</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>			
d. STREET ADDRESS <b>Westminster, Md. R. D. 6</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Arthur</b> Last <b>Miller</b>				4. DATE OF DEATH Month <b>2/4/58</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/17/1938</b>	9. AGE (In years last birthday) yrs. <b>19</b>	IF UNDER 1 YEAR Months <b></b> Days <b></b> Hours <b></b> Min. <b></b>	IF UNDER 24 HRS. Hours <b></b> Min. <b></b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None - Invalid</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>None - Invalid</b>		11. BIRTHPLACE (State or foreign country) <b>Carroll Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Arthur N. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Mary Humbert</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Arthur N. Miller</b> Address <b>Arthur N. Miller, Westminster, Md. R.D. 6</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bleeding Gastric Ulcer</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO (c) <b></b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 M O S.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Palsy from birth</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b></b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 10, 1957</b> , to <b>Feb 4, 1958</b> , that I last saw the deceased alive on <b>Feb 4, 1958</b> , and that death occurred at <b>6:45 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Julius Chepko</b>		M.D. <b>E. S. W. Green, Jr.</b>		ADDRESS (Street, city or town, state) <b>Westminster, Md</b>		DATE SIGNED <b>2/4/58</b>	
PHYSICIAN'S NAME (Type) <b>Julius Chepko</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/7/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baust Church Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Nr. Taneytown, Carroll Co., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>				ADDRESS <b>Littlestown, Pa.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 8 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Ch. Little</b>			

BOULEVARD V. S.

FEB. 6 193

RECEIVED

1849

## CERTIFICATE OF DEATH

Reg. Dist. No. 01840

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. Co.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sparrows Pt., Balto., 19.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Burton</b> Last <b>MILLER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>8</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 20, 1909</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Crane Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hugh B. Miller</b>		14. MOTHER'S MAIDEN NAME <b>Bessie Adams</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-04-1491</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Starvation</b> <b>300.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-</b> DUE TO (c) <b>-</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, catatonic type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>February 8, 1958</b> , that I last saw the deceased alive on <b>February 7, 1958</b> , and that death occurred at <b>12:05 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b> DATE SIGNED <b>2/8/58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland.</b>	
22a. BURIAL, CREMATION, OR OTHER DISPOSITION (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/13/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CRANFORD</b>		22d. LOCATION (City, town, or county) (State) <b>Balto. Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Walter Brooke Bradley</b>		ADDRESS <b>Hundred, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. B. Bradley</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

13 4 2 1980

RECEIVED  
FBI

1850

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>1651 Eager St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Irving</b> Middle <b>MILLS</b> Last <b>MILLS</b>		4. DATE OF DEATH Month <b>February</b> Day <b>12,</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1883</b>
9. AGE (In years last birthday) <b>74</b> yrs		IF UNDER 1 YEAR: Months <b>74</b> Days <b>74</b> Hours <b>74</b> Min. <b>74</b>	
10a. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) <b>Book-keeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Thomas Allen Mills</b>		14. MOTHER'S MAIDEN NAME <b>Ida Brooks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no; unknown) <b>No</b>		16. SOCIAL SECURITY NO <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Infarction of myocardium due to arteriosclerotic coronary thrombosis</b> DUE TO <b>Minutes</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Coronary</b> (b) <b>-</b> (c) <b>-</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenia, catatonic type. Pulmonary tuberculosis, moderately advanced, active.</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-</b>		20f. (City or town) (County) (State) <b>-</b>	
21. I certify that I attended the deceased from <b>Sept. 27, 19 55</b> to <b>February 12, 19 58</b> , that I last saw the deceased alive on <b>February 11, 19 58</b> , and that death occurred at <b>4:20 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/12/58</b> ACTUAL SIGNATURE <b>Julian Radd, M.D.</b> M. D. <b>Springfield State Hospital</b> PHYSICIAN'S NAME (Type) <b>Julian Radd, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-14-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard H. Hubbard</b>		24a. REC'D BY REGISTRAR <b>FEB 14 58</b>	
ADDRESS <b>4107 Wilkens Avenue</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN V. S.

EB

RECEIVED

## CERTIFICATE OF DEATH

01842

1851

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CARROLL</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>CARROLL</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Woodline</u>		LENGTH OF STAY (in this place) <u>30 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Airy</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Weitzel Nursing Home</u>				STREET ADDRESS <u>Home</u>		(If rural give location)	
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>W.</u> (Last) <u>MURPHY</u>				(Month) <u>Feb</u> (Day) <u>28</u> (Year) <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>MARCH 3-1867</u>	9. AGE last birthday <u>90</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Murphy</u>				14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>John C. Murphy, Churchton Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis, arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Jan 58</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized senility, aneurysm,</u>				<u>to</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				<u>28 Feb 58</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 28 Feb 1958</u> , to <u>28 Feb 1958</u> , that I last saw the deceased alive on <u>28 Feb 1958</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Howard E. Hall</u> M.D.				ADDRESS (Street, city, town, state) <u>Apesville, Md</u> DATE SIGNED <u>28 Feb 58</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 3-58</u>		NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery, Charlesburg Md</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>W. Search</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sammons Brothers 1661 - 9th Hope Rd. S.E. Wash DC</u>		ADDRESS	
DATE <u>MAR 3 '58</u>							

**INSTRUCTIONS:** The law requires that the death certificate be executed within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this time, the bottom copy may be retained by the hospital or attending physician.

death certificate assembly should be detached for use as a burial transit permit.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1852

## CERTIFICATE OF DEATH

Reg. Dist. No. 02604

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Carroll</u> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sykesville</u>			c. LENGTH OF STAY IN 1b <u>5 days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springfield State Hospital</u>				d. STREET ADDRESS <u>412 N. Chester Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>Addie</u> <u>ORWIG</u>		<b>4. DATE OF DEATH</b> Month Day Year <u>February</u> <u>19</u> <u>1958</u>					
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>unknown</u>	<b>9. AGE</b> (In years lost birthday) <u>79</u> yrs.	<b>IF UNDER 1 YEAR</b> <b>IF UNDER 24 HRS</b> Months Days Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>-</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unknown) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>-</u>		<b>17. INFORMANT</b> Address <u>Springfield State Hospital Records</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491x</u> Not DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } (b) <u>Arteriosclerotic heart disease</u> DUE TO (c) <u>Generalized arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u>  <u>Years</u>  <u>Years</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Brain Syndrome associated with general arteriosclerosis</u>						<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)		
<b>21. I certify</b> that I attended the deceased from <u>February 14, 1958</u> , to <u>February 19, 1958</u> , that I last saw the deceased alive on <u>February 19, 1958</u> , and that death occurred at <u>12:15 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Springfield State Hospital</u> DATE SIGNED _____							
<b>ACTUAL SIGNATURE</b> <u>Edmund Lusthaus</u> M.D.			<b>PHYSICIAN'S NAME</b> (Type) <u>Edmund Lusthaus, M.D.</u> <u>Sykesville, Maryland</u>				
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>2/24/58</u>	<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Baltimore</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Philip Herwig</u> ADDRESS <u>2024 Orleans St</u>			<b>24a. REC'D BY REGISTRAR</b> DATE <u>FEB 24 '58</u>		<b>24b. REGISTRAR'S SIGNATURE</b>		

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

EB 64 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1853

## CERTIFICATE OF DEATH

Reg. Dist. No.

01843

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>			c. LENGTH OF STAY IN 1b <b>31 yrs. 18 days</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>			d. STREET ADDRESS <b>unknown</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Thomas</b> Middle <b>Henry</b> Last <b>Pritchett</b>			4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-11-1886</b>	9. AGE (In years last birthday) <b>71</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>William Pritchett</b>			14. MOTHER'S MAIDEN NAME <b>Margaret J. White</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War I</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial infarction due to coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Dementia praecox, paranoid type, on a constitutional psychopathic personality basis.</b>					INTERVAL BETWEEN ONSET AND DEATH <b>hours</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Springfield State Hospital</b>	
20f. (City or town) <b>Balto., Md.</b>		20g. (County) (State)			
21. I certify that I attended the deceased from <b>March 7, 1955</b> , to <b>February 18, 1958</b> , that I last saw the deceased alive on <b>February 17, 1958</b> , and that death occurred at <b>9:48 A.M.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Agustin del Campo</b>		M.D. <b>Springfield State Hospital</b>		DATE SIGNED <b>2-18-58</b>	
PHYSICIAN'S NAME (Type) <b>Agustin del Campo, M.D.</b>		<b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/24/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>	
22d. LOCATION (City, town, or county) <b>Balto., Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. J. Tiekert &amp; Sons - Balto 17, Md.</b>		ADDRESS <b>Balto 17, Md.</b>		24a. REC'D BY REGISTRAR <b>Feb 24 1958</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. Tiekert</b>					

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 14 1963

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1854

## CERTIFICATE OF DEATH

01844

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>_____</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>21 S. Broadway</b>	
3. NAME OF DECEASED (Type or print) First <b>Theodore</b> Middle <b>Francis</b> Last <b>REGEL</b>		4. DATE OF DEATH Month <b>February</b> Day <b>20</b> Year <b>19 58</b>	
5. SEX <b>male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 19, 1896</b>
9. AGE (In years last birthday) yrs. <b>61</b>		IF UNDER 1 YEAR IF UNDER 24 HRS Months <b>—</b> Days <b>—</b> Hours <b>—</b> Min. <b>—</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
13. FATHER'S NAME <b>Maxamillan Regel</b>		14. MOTHER'S MAIDEN NAME <b>Mary Fuchs</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>217-07-5300</b>	
17. INFORMANT <b>Records of Springfield State Hospital</b>		Address <b>Sykesville, Md.</b>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>443 X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive cardiovascular disease</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>  <b>Years</b>
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>—</b>	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m. p. m.</b> <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) <b>—</b>	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from **July 3, 1956**, to **Feb. 20, 1958**, that I last saw the deceased alive on **Feb. 20, 1958**, and that death occurred at **2:20 PM**, from the causes and on the date stated above.

ADDRESS (Street, city or town, state) **M. D. Springfield State Hospital** DATE SIGNED **2/20/58**

ACTUAL SIGNATURE **Martin Gross** M. D. **Sykesville, Maryland**

PHYSICIAN'S NAME (Type) **Martin Gross, M. D.**

22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>2-24-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>SACRED HEART CEM.</b>	22d. LOCATION (City, town, or county) (State) <b>1401 GERMAN HILL RD., MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles J. Giller</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 25 '58</b>	24b. REGISTRAR'S SIGNATURE <b>W. J. Redman</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

BUREAU V. P.

1915

1855

## CERTIFICATE OF DEATH

Reg. Dist. No.

01845

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Springfield, Sykesville</b>				c. LENGTH OF STAY IN 1b <b>1yr. 4mos. 12days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>3709 Monterey Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>Florence</b> Middle <b>Miriam</b> Last <b>Dalzell ROOS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>September 5, 1879</b>	9. AGE (In years last birthday) <b>78</b> yrs	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Dalzell</b>				14. MOTHER'S MAIDEN NAME <b>Florence Kennedy</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT <b>Springfield Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Anemia, hypochromic microcytic, generally &amp; unspecified</b> DUE TO <b>271x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>W.B.S. associated with dist. of metabolism, growth or nutrition, with senile brain disease, with psychotic reaction.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Sept. 13, 1956</b> to <b>February 25, 1958</b> , that I last saw the deceased alive on <b>February 25, 1958</b> , and that death occurred at <b>10:30AM</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/25/58</b>							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b> M.D.				PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/27.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hedgesville</b>		22d. LOCATION (City, town, or county) (State) <b>Hedgesville, W.Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Howard K. Brown</b>				ADDRESS <b>Martinsburg, W.Va.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 28 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. W. Adams</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 28 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1856

## CERTIFICATE OF DEATH

Reg. Dist. No. 11846

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution—Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write <u>Manchesters</u> and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write <u>Manchesters</u> and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>R.R. #1</u>		d. STREET ADDRESS <u>R.R. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>J</u> Last <u>Roser</u>		4. DATE OF DEATH Month <u>Feb</u> Day <u>28</u> Year <u>1958</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/2/1877</u>
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carroll Co Md</u>	
11. BIRTHPLACE (State or foreign country) <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Beriah Bankert</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Beagle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Notman Roser</u> Address <u>Manchesters Pa #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X</u> DUE TO <u>arteriosclerotic heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>Arterio Sclerosis Generalized</u> (c) <u>Nephritis Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>14 yr</u> <u>10 yr</u> <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Typhoid</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>5</u> p. m. 19 <u>58</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 5</u> , 19 <u>58</u> , to <u>Feb 28</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Feb 28</u> , 19 <u>58</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>George E Thomas</u>		PHYSICIAN'S NAME (Type) <u>George E Thomas</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/3/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>		22d. LOCATION (City, town, or county) (State) <u>Carroll Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Frederick Becker</u> ADDRESS <u>Hawners Fe</u>		24a. REC'D BY REGISTRAR <u>58</u> DATE <u>Mar 4</u>	
		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU

1978



1857

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville (rural)</b>		c. LENGTH OF STAY IN TB <b>3 mo. 7 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Springfield State Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Vallie</b> Middle <b>Octavia</b> Last <b>Burgee Runkles</b>		4. DATE OF DEATH Month <b>2</b> Day <b>20</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6-23-75</b>
9. AGE (In years last birthday) <b>82</b> yrs.		10. IF UNDER 1 YEAR Months <b>02</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>	11. IF UNDER 24 HRS Months <b>00</b> Days <b>00</b> Hours <b>00</b> Min. <b>00</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Mile Eldridge Burgee</b>		14. MOTHER'S MAIDEN NAME <b>Sara Ida Davis</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>—</b>	
17. INFORMANT <b>Springfield State Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Mesenteric thrombosis.</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease.</b> DUE TO (c) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome associated with cerebral arteriosclerosis, with psychotic reaction.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>o. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11-13-</b> <b>1957</b> to <b>2-20</b> <b>1958</b> , that I last saw the deceased alive on <b>2-20-</b> <b>1958</b> , and that death occurred at <b>11:50p M.</b> from the causes and on the date stated above. <b>Gertrude M. Gross, M.D.</b> ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2-25-58</b> <b>Gertrude M. Gross, M.D.</b> <b>Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Interment</b>		22b. DATE THEREOF <b>2-23-1958</b>	
22c. NAME OF CEMETERY OR CREMAIORY <b>Prospect</b>		22d. LOCATION (City, town, or county) (State) <b>Frederick Co. Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. M. Wertz</b>		24a. REC'D BY REGISTRAR <b>Winfried Md</b>	
24b. REGISTRAR'S SIGNATURE <b>Winfried Md</b>		DATE <b>2-25-58</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

18



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

1858

Reg. Dist. No. 01848

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>19yrs.8mos.1day</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>-</b>	
e. IS RESIDENCE ON FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Francis</b> Middle <b>A.</b> Last <b>SALTER</b>		4. DATE OF DEATH Month <b>February</b> Day <b>15</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 12, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs		10. IF UNDER 1 YEAR Months <b>83</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farm laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Felix A. Salter</b>		14. MOTHER'S MAIDEN NAME <b>Martha A. Crippen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardiovascular disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, paranoid type.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>October 20, 1954</b> to <b>February 15, 1958</b> , that I last saw the deceased alive on <b>February 14, 1958</b> , and that death occurred at <b>2:31A M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		ADDRESS (Street, city or town, state) <b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2/20/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>GLENWOOD CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Warner E. Humphrey</b>		24a. REC'D BY REGISTRAR <b>FEB 24 58</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>(Signature)</b>	

TO HOSPITAL ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BURMAN V. S.

FEB 24 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1802

## CERTIFICATE OF DEATH

01849

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CARROLL</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CARROLL</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WESTMINSTER</b>			
c. LENGTH OF STAY IN 1b <b>40 YRS.</b>				d. STREET ADDRESS <b>55 PENNA. AVE.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>55 PENNA. AVE.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>ELIZABELLE SCHAEFFER</b>				4. DATE OF DEATH <b>FEB. 1ST, 1958</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>SEPT. 14, 1900</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE-WIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (State or foreign country) <b>FAYETTE CO. PENNA.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>WILLIAM W. SMITH</b>		14. MOTHER'S MAIDEN NAME <b>IDA BITNER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>MR. C. RUSSELL SCHAEFFER, WESTMINSTER, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]							
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute hemorrhage caused by erosion</b>							
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. <b>Carcinoma of mandible through External Carotid Artery</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>—</b>				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Aug. 10, 1957</b> to <b>Feb 15, 1958</b> , that I last saw the deceased alive on <b>Feb 1, 1958</b> , and that death occurred at <b>1A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Shuster Bare</b> M.D.				DATE SIGNED <b>2/2/58</b>			
PHYSICIAN'S NAME (Type) <b>S. LUTHER BARE</b>							
22a. BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>FEB. 3, 58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KRIDERS CEMETERY RURAL, WESTMINSTER, MD.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. E. Meyer, Jr. Westminister, Md.</b>				24a. REC'D BY REGISTRAR <b>—</b> DATE <b>FEB 3 '58</b>			
24b. REGISTRAR'S SIGNATURE <b>—</b>				24c. REGISTRAR'S SIGNATURE <b>—</b>			

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 of 3. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

123

RECEIVED  
JAN 10 1900

1859

CERTIFICATE OF DEATH

01850

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		c. LENGTH OF STAY IN 1b <u>X</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Maggie</u> Middle <u>Virginia</u> Last <u>Senft</u>				4. DATE DEATH Month <u>February</u> Day <u>17</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 17, 1870</u>		9. AGE (In years lost birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Haifley</u>				14. MOTHER'S MAIDEN NAME <u>Clarissa Stonesifer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO <u>none</u>		17. INFORMANT Address <u>Miss Eliza Senft, Taneytown, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Cardiac Deilitation</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-6-1958</u> to <u>2-17-1958</u> , that I last saw the deceased alive on <u>2-6-1958</u> , and that death occurred at <u>3 P. M.</u> from the causes and on the date stated above							
ACTUAL SIGNATURE <u>J. N. Legg</u>		M.D. <u>Union Bridge</u>		ADDRESS (Street, city or town, state) <u>UNION BRIDGE Md</u>		DATE SIGNED <u>2/20/58</u>	
PHYSICIAN'S NAME (Type) <u>T. H. LEGG</u>		<u>M.D.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/20/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mervyn C. Fuss</u>				ADDRESS <u>Taneytown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 24 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>  </u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: This low requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

FEB 24 1958

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1860

## CERTIFICATE OF DEATH

01851

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Westminster</b>		c. LENGTH OF STAY IN lb <b>life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>R.F.D. # 4 Reese</b>		d. STREET ADDRESS <b>R.F.D. # 4 Reese</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Elby</b> Last <b>Shipley</b>		4. DATE OF DEATH Month <b>February</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>February 4, 1883</b>
9. AGE (In years last birthday) <b>75</b> yrs		IF UNDER 1 YEAR Months <b>7</b> Days <b>10</b> Hours <b>19</b> Min.	IF UNDER 24 HRS Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Meat Store</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>Theodore Shipley</b>		14. MOTHER'S MAIDEN NAME <b>Amanda Green</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <b>212-03-1300</b>	
17. INFORMANT <b>Eugene Shipley R 1 Finksburg, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>592x</b> DUE TO <b>Uremia, Nephritis (chr) Myocarditis (chr)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Peritonitis (chr) Cardiac Asthma</b> (c) <b>?</b>		INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 11, 1957</b> to <b>Feb 11, 1958</b> , that I last saw the deceased alive on <b>2-10-58</b> and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm C. Jennette</b> M.D.		ADDRESS (Street, city or town, state) <b>103 E Main Westminster Md</b>	
PHYSICIAN'S NAME (Type) <b>W. C. Jennette, M.D.</b>		DATE SIGNED <b>2-11-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2-12-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Carrollton Church of God</b>		22d. LOCATION (City, town, or county) (State) <b>Carrollton, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John R. Byers</b>		ADDRESS <b>Westminster, Maryland</b>	
24a. REC'D BY REGISTRAR <b>FEB 13 58</b>		24b. REGISTRAR'S SIGNATURE <b>W. C. Jennette</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained in the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD V. S.

1900

RECEIVED

1861

## CERTIFICATE OF DEATH

Reg. Dist. No. 01852

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Henryton</b>				c. LENGTH OF STAY IN TB <b>77 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Henryton State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				d. STREET ADDRESS <b>631 W. Conway Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>Springfield</b> Last				4. DATE OF DEATH Month <b>February</b> Day <b>12</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>May 8, 1882</b>	
				9. AGE (In years last birthday) yrs <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Porter</b>				10b. KIND OF BUSINESS OR INDUSTRY			
				11. BIRTHPLACE (State or foreign country) <b>Lauringburg, N. C.</b>			
				12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes War I</b>				16. SOCIAL SECURITY NO.			
				17. INFORMANT Address <b>Richard Springfield 631 W. Conway Street</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Cardiovascular insufficiency</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>Far advanced bilateral pulmonary tuberculosis</b> (c) <b>Far advanced bilateral pulmonary tuberculosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Far advanced bilateral pulmonary tuberculosis</b>							
INTERVAL BETWEEN ONSET AND DEATH							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Nov. 27 1957</b> , to <b>Feb. 12 1958</b> , that I last saw the deceased alive on <b>Feb. 12 1958</b> , and that death occurred at <b>12:00 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edgars M. Maculans</b>				ADDRESS (Street, city or town, state) <b>Henryton, Maryland</b>			
DATE SIGNED <b>2-12-58</b>							
PHYSICIAN'S NAME (Type) <b>Dr. Edgars M. Maculans</b>							
Henryton State Hospital, Henryton, Md.							
22a. BURIAL CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2/15/58</b>		<b>St. Luke's</b>		<b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles A. Rice</b>				ADDRESS <b>661 W. Barre St</b>			
24a. REC'D BY REGISTRAR <b>2-12-58</b>				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

FEB 1

BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1862

## CERTIFICATE OF DEATH

01853

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Carroll</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Taneytown</u>				c. LENGTH OF STAY IN 1b <u>X</u> Rural <u>Taneytown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>/</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Alveta</u> Middle <u>Elizabeth</u> Last <u>Stauffer</u>				4. DATE OF DEATH Month <u>February</u> Day <u>21</u> Year <u>1958</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>November 12, 1971</u>		9. AGE (In years last birthday) <u>86</u> yrs	IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Penna.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>							
13. FATHER'S NAME <u>Daniel Reicle</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mr. Harry Stauffer, Taneytown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0 Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Congestive Heart Failure</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour <u></u> a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 27</u> , 1957, to <u>Feb 3</u> , 1958, that I last saw the deceased alive on <u>Feb 3</u> , 1958, and that death occurred at <u>—</u> M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>E. Ambler Thompson</u> M.D.				DATE SIGNED <u>Feb 23, 1957</u>			
PHYSICIAN'S NAME (Type) <u>E. Ambler Thompson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Feb. 24, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lutheran Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Taneytown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Merwyn C. Fuss</u>				ADDRESS <u>Taneytown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U.S. DEPARTMENT OF AGRICULTURE

1918

DEPT. OF AGRICULTURE

1863

## CERTIFICATE OF DEATH

Reg. Dist. No. 01854

1. PLACE OF DEATH a. COUNTY <b>Carroll</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>1 month, 5 days</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				e. STREET ADDRESS <b>821 N. Chapel St.</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Gombert</b> Last <b>STRASSLE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>19</b> Year <b>19 58</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1874</b>		9. AGE (In years last birthday) <b>83</b> yrs.		10. IF UNDER 1 YEAR Months <b>83</b>		11. IF UNDER 24 HRS. Days <b>83</b>		12. IF UNDER 24 HRS. Hours <b>83</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Frank Gombert</b>				14. MOTHER'S MAIDEN NAME <b>Reginia</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-22-8939</b>		17. INFORMANT <b>Springfield State Hospital Records</b>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>423.0 Not</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Days</b> <b>Years</b> <b>Years</b>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome due to marked arteriosclerosis.</b>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Springfield State Hospital</b>		(County) (State)	
21. I certify that I attended the deceased from <b>January 14, 19 58</b> , to <b>February 19, 19 58</b> , that I last saw the deceased alive on <b>February 19, 19 58</b> , and that death occurred at <b>8:45 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/19/58</b>									
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>							
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>							
22a. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-24-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>HOLY REDEEMER</b>		22d. LOCATION (City, town, or county) (State) <b>MD</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Frank Couch &amp; Son</b>				ADDRESS <b>900 N. Chester St</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 21 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Couch</b>	

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

1 2 3

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1864

## CERTIFICATE OF DEATH

01855

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NEW WINDSOR RURAL</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>WALTER ROY STRINE</u>				4. DATE OF DEATH Month Day Year <u>FEB 23 1958</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 12 - 1890</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>CHARLES C STRINE</u>				14. MOTHER'S MAIDEN NAME <u>ROSIE HARRIS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>ETHEL H STRINE</u>				Address <u>RURAL NEW WINDSOR MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure + Diabetes,</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis.</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u> <u>years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>New</u> , 19 <u>56</u> to <u>2/23</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>2/10/58</u> , 19 <u>58</u> , and that death occurred at <u>10:30</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>M. E. Robertson</u> M.D. <u>New Windsor, Md</u> <u>2/23/58</u> PHYSICIAN'S NAME (Type) <u>ME ROBERTSON</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2/26/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SAMS CREEK</u>		22d. LOCATION (City, town, or county) (State) <u>CARROLL CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>DR Hartzler &amp; Sons</u>				ADDRESS <u>New Windsor, Md</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 25 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Over</u>							

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the general director, page 3 should be detached for use as the burial-transit permit. Then please remove coroner papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

JOHN V. S.

83

RECEIVED

VS A15 (4)  
15M 9/55

DOMINION V. S.

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1866

## CERTIFICATE OF DEATH

Reg. Dist. No.

01857

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) b. COUNTY <b>Maryland</b> <b>Carroll</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, Nr. Westminster</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Westminster, Md. R.D.1 (Silver Run)</b>		d. STREET ADDRESS <b>Westminster, Md. R.D.1 (Silver Run)</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Rosa - Tipton</b>		4. DATE OF DEATH Month Day Year <b>February 1, 1958 19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife-Housework</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Her own home</b>	
11. BIRTHPLACE (State or foreign country) <b>Roan Mountain, Tenn.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>John Forbes</b>		14. MOTHER'S MAIDEN NAME <b>Vista Hughes</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Andrew Gregg</b> Address <b>Mrs. Andrew Gregg, Westminster, Md. R.D.1</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b> <b>104 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 28, 1957</b> , to <b>February 1, 1958</b> , that I last saw the deceased alive on <b>December 31, 1957</b> , and that death occurred at <b>8:45 A. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Leah Matlan</b> M.D. <b>Littlestown, Pa.</b> PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>2/5/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Monte Vista Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Johnson City, Washington Co., Tenn.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Richard A. Little</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 4 '58</b>	
ADDRESS <b>Littlestown, Pa.</b>		24b. REGISTRAR'S SIGNATURE <b>Alber...</b>	

U. S. A.

1953

DEATH

1867

## CERTIFICATE OF DEATH

Reg. Dist. No.

1858

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Balto. City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 23 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>		d. STREET ADDRESS <b>Baltimore 5, Md.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lena Barbara Kutcher TWILLEY</b>		4. DATE OF DEATH Month Day Year <b>February 12, 1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 20, 1887</b>
9. AGE (In years last birthday) yrs. <b>70</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>1958</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Kutcher</b>		14. MOTHER'S MAIDEN NAME <b>Anna Roubal</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>---</b>	
17. INFORMANT <b>Springfield Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage due to hypertension</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>C.B.S. associated with cerebral arteriosclerosis, with psychotic reaction.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Hours</b>			
19. WAS AUTOPSY PERFORMED? <b>NO</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month Day Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>November 19, 1957</b> to <b>2/12/58</b> , that I last saw the deceased alive on <b>February 12, 1958</b> , and that death occurred at <b>6:50 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital</b> DATE SIGNED <b>2/13/58</b>			
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>		M.D. <b>Springfield State Hospital</b>	
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>		<b>Sykesville, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>	22b. DATE THEREOF <b>2-17-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer</b>	22d. LOCATION (City, town, or county) (State) <b>Balto. G. Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>FRANK Cwach &amp; Son</b>		24. REC'D BY REGISTRAR DATE <b>FEB 14 58</b>	
ADDRESS <b>900 N. Chester St. Balt. Md.</b>		24b. REGISTRAR'S SIGNATURE <b>---</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

HONORARY V. S.

NOV 1 1900

RECEIVED

1  
INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.  
The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

01859

1868  
CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Carroll</b>		STATE <b>Maryland</b>		COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Westminster (Rural)</b>		LENGTH OF STAY (In this place) <b>6 Months</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
TOWN				STREET ADDRESS <b>1315 E. North Avenue</b>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Wimert Nursing Home</b>							
<b>3. NAME OF DECEASED</b> (Type or Print) <b>George S. Updegraff</b>				<b>4. DATE OF DEATH</b> (Month) <b>Feb.</b> (Day) <b>5</b> (Year) <b>19 58</b>			
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Married</b>		<b>8. DATE OF BIRTH</b> <b>July 2, 1875</b>	
				<b>9. AGE last birthday</b> <b>82 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Latherer (Ret'd)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Snow Hill, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>	
<b>13. FATHER'S NAME</b> <b>Samuel Updegraff</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Isabelle Mitchell</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>No</b>		<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>John E/ Updegraff 2627 Garrett Ave</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>1. IMMEDIATE CAUSE</b> (A) <b>Cardiac Decompensation</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>2 days</b>			
<b>2. ANTECEDENT CAUSE(S)</b> (B) <b>Cardio Vascular Disease</b>				<b>?</b>			
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <b>Smoking</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, notify medical examiner)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 10-5-58, to 2-5-58, 1958, that I last saw the deceased alive on 2-5-58, 1958, and that death occurred at M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>W. E. Atwell</b>				<b>ADDRESS</b> (Street, city, town, state) <b>M.D. 121 E. North St. Westminster 2-5-58</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 8, 1958</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Carmel Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>FEB 7 '58</b>		<b>REGISTRAR'S SIGNATURE</b> <b>W. E. Atwell</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>William Cook, Inc. 1217 St. Paul Street</b>			

BUREAU V. S.

FEB 7 1938

RECEIVED

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1803 Item 8 Fil 3225 2-25-58 et

Reg. Dist. No. 1860

1. PLACE OF DEATH a. COUNTY <u>CARROLL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CARROLL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WESTMINSTER</u>	
c. LENGTH OF STAY IN 1b <u>12 1/2 Yrs.</u>		d. STREET ADDRESS <u>E. GREEN ST.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>E. GREEN ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE LEE VIRTZ</u>		4. DATE OF DEATH Month <u>FEB</u> Day <u>18</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1890 Feb. 28, 1890</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Fred. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EMORY SCOTT BOONE</u>		14. MOTHER'S MAIDEN NAME <u>Mary Alice Fogle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. R.T. HAINES, WESTMINSTER MD.</u>		Address <u>27 WEBSTER ST.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 381X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>James T. Marsh</u>		DATE SIGNED <u>2/19/58</u>	
EXAMINER'S NAME (Type) <u>JAMES T. MARSH</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. PLURAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/24/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>BEAVER DAM CEMETERY</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL UNION BRIDGE MD.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Meyer, Jr. Westminster Md.</u>		24a. REC'D BY REGISTRAR <u>—</u>	24b. REGISTRAR'S SIGNATURE <u>—</u>

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JAN 1 1914

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1869

## CERTIFICATE OF DEATH

01861

Reg. Dist. No.

1 PLACE OF DEATH a. COUNTY <u>Danell</u> MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Danell</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Chynowille</u>		c. LENGTH OF STAY IN 1b <u>4 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Chynowille P.O.</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) <u>OR INSTITUTION</u> <u>Oklahoma Rd.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS <u>Oklahoma Rd.</u>	
3 NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM SANDFORD WIDERMAN</u>		4. DATE OF DEATH Month Day Year <u>February I 1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 8, 1891</u>
9. AGE (In years last birthday) <u>66</u> yrs		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. Construction</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Wideman</u>		14. MOTHER'S MAIDEN NAME <u>Katie M. Gill</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY NO. <u>217-01-7073</u>	
17. INFORMANT <u>Mrs. Rosa A. Wideman</u>		Address <u>Chynowille, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Obesity + generalized arteriosclerosis</u> DUE TO (c) <u>Cardiac failure</u>			INTERVAL BETWEEN ONSET AND DEATH <u>few minutes</u> <u>20 years</u> <u>6 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostate hypertrophy</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September, 1953</u> to <u>January, 1958</u> , that I last saw the deceased alive on <u>January 27, 1958</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Bertrand R. Gau</u> M.D. <u>37 Central Ave</u>		DATE SIGNED <u>2-1-58</u>	
PHYSICIAN'S NAME (Type) <u>Bertrand R. GAU</u>		<u>Sykesville, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2-5-58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MT Olive</u>	22d. LOCATION (City, town, or county) (State) <u>Randallstown, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur A. Haight</u> ADDRESS <u>Sykesville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>Feb 4 1958</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur A. Haight</u>

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

U. S. A.

1968

RECEIVED

1870

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>---</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Sykesville</b>				c. LENGTH OF STAY IN 1b <b>since 3/29/06</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital</b>				d. STREET ADDRESS <b>---</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Clarence</b> Middle <b>-</b> Last <b>WILKINS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>25</b> Year <b>1958</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>unknown 7/21/79</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>		IF UNDER 24 HRS. Months <b>---</b> Days <b>---</b> Hours <b>---</b> Min. <b>---</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>							
13. FATHER'S NAME <b>Charles H. Wilkins</b>				14. MOTHER'S MAIDEN NAME <b>Alice M. Johnson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Records of Springfield State Hospital</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X INDEX</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Old myocardial infarction</b> DUE TO (c) <b>Arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>months</b> <b>II</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic reaction, hebephrenic type</b>				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>---</b>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month <b>---</b> Day <b>19</b> Year <b>---</b> Hour <b>---</b> a. m. <b>---</b> p. m. <b>---</b>				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>				20g. (County) <b>---</b>		20h. (State) <b>---</b>	
21. I certify that I attended the deceased from <b>October 20, 1954</b> , to <b>February 25, 1958</b> , that I last saw the deceased alive on <b>February 25, 1958</b> , and that death occurred at <b>8:55 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Edmund Lusthaus</b>				DATE SIGNED <b>2/25/58</b>			
PHYSICIAN'S NAME (Type) <b>Edmund Lusthaus, M.D.</b>				ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 27, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John O. Mitchell &amp; Sons Inc. 1900 Eutaw Place</b>				24a. REC'D BY REGISTRAR <b>FEB 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>---</b>	

MEDICAL CERTIFICATION

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

FEB 27 1958

RECEIVED

John C. Kennedy & Sons Inc. 1000 Boylston Street  
Tel. 27-1050  
BOSTON, MASS.

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1871 CERTIFICATE OF DEATH

Reg. Dist. No. 01863

1. PLACE OF DEATH a. COUNTY <b>Carroll</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City 311</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sykesville</b>				c. LENGTH OF STAY IN 1b <b>16 days</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore 17</b>				3. NAME OF DECEASED (Type or print) First <b>Benjamin</b> Middle <b>Whitely</b> Last <b>Woolford</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Springfield State Hospital.</b>				d. STREET ADDRESS <b>1903 Park Avenue</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
4. DATE OF DEATH Month <b>2</b> Day <b>15</b> Year <b>1958</b>							
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>2-25-71</b>	
9. AGE (In years and birthday) <b>86</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Druggist</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>			
11. BIRTHPLACE (State or foreign country) <b>Unknown Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>Unknown U.S.A.</b>			
13. FATHER'S NAME <b>Unknown Benjamin Woolford</b>				14. MOTHER'S MAIDEN NAME <b>(Unknown) Skinner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Unknown</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Hospital records.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>491X not</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Arteriosclerosis heart disease</b> DUE TO (c) <b>Generalized arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>days</b> <b>years</b> <b>years</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). <b>C.B.S. associated with senile brain disease, with psychotic reaction.</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>1-30-</b> , <b>1958</b> , to <b>2-15-</b> , <b>1958</b> , that I last saw the deceased alive on <b>2-15-</b> , <b>1958</b> , and that death occurred at <b>10:40 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Springfield State Hospital, Sykesville</b> DATE SIGNED <b>2-16-58</b>							
ACTUAL SIGNATURE <b>Agustin del Campo</b>				M.D. <b>Springfield State Hospital, Sykesville</b>			
PHYSICIAN'S NAME (Type) <b>Agustin del Campo.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>2-18-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Cook, Inc., 1217 St. Paul Street</b>				24a. REC'D BY REGISTRAR DATE <b>FEB 18 1958</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>	

# CERTIFICATE OF DEATH

INDIAN STATE DEPARTMENT OF HEALTH-BALTIMORE 11

**RECEIVED**  
FEB 18 1953  
BUREAU V. 2

*George H. Jones*